STATE OF DELAWARE

DELAWARE HEALTH
AND SOCIAL SERVICES
DIVISION OF MEDICAID
AND MEDICAL
ASSISTANCE
1901 N. DuPont Highway
New Castle, DE 19720

REQUEST FOR INFORMATION

FOR

MANAGED CARE HEALTH INSURANCE FOR CHILDREN AGES 0 – 18
A CHIP LOOK ALIKE PROGRAM

FOR

DIVISION OF MEDICAID & MEDICAL ASSISTANCE
HERMAN M. HOLLOWAY SR. CAMPUS
LEWIS BUILDING
1901 N. DUPONT HIGHWAY
NEW CASTLE, DE 19720

Responses Due By: November 13, 2009 @ 4:30 PM EST Local Time

The purpose of this Request for Information (RFI) is to solicit information, comments, suggestions and determine the level of interest among health insurance entities and other interested parties that will enable the Department of Health and Social Services to develop a possible Request for Proposal (RFP) to provide comprehensive health insurance to children ages 0 through age 18 in families with income above 200% of the federal poverty level that would look like the existing CHIP program.

The program envisioned would be similar to the current Delaware Healthy Children Program (DHCP). This is Delaware's Children Health Insurance Program (CHIP) which is funded with Federal and State funds. The State is developing a CHIP look-alike insurance plan that is fully operated by a commercial insurance company that will cover all of the same health care services provided by the existing CHIP program, but fully paid from premiums collected by the insurance company from the families who enroll their children. Families covered by the existing CHIP program have incomes under 200% of the federal poverty level. The new CHIP look-alike program will allow any family with income above 200% of the poverty level to pay a monthly premium and enroll their children into the look-alike program.

The Delaware Department of Health and Social Services (DHSS) hopes to achieve the following objectives through this RFI process: (1) provide information to all interested parties about the State's plans for managed care health insurance coverage for children; (2) to solicit comments and suggestions from entities potentially interested in providing health insurance to children in Delaware; and (3) to receive comments and suggestions from those who would be covered by the program, their families and other interested parties that would help the state design a viable program.

Responses from interested vendors, families or other parties regarding this RFI will be received by Frank O'Connor, Division of Medicaid and Medical Assistance, Delaware Health and Social Services, Herman M. Holloway Sr. Campus, Lewis Building, 1901 North DuPont Highway, New Castle, Delaware 19720, until 4:30 PM EST on November 13, 2009.

For further information concerning this RFI, please contact Frank O'Connor at (302) 255-9615 or via e-mail to: frank.oconnor@state.de.us.

OVERVIEW OF REQUEST FOR INFORMATION

The Department of Health and Social Services (DHSS)

The Delaware DHSS of Health and Social Services is an umbrella agency responsible for most of the State's health-related services. Included among its twelve (12) divisions are:

a. Medicaid and Medical Assistance
b. Social Services
c. Substance Abuse and Mental Health, which serves adults
d. Public Health
e. Developmental Disabilities Services
f. Services for Aging and Adults with Physical Disabilities
g. Visually Impaired
h. State Service Centers, which operates a Statewide network of integrated service delivery locations
i. The Office of the Chief Medical Examiner
j. Child Support Enforcement
k. Management Services, which is a support Division for the Entire DHSS
l. Long Term Care and Residents Protection

Division of Medicaid and Medical Assistance (DMMA) -- Medicaid & CHIP Managed Care Program Overview

The Delaware DHSS of Health and Social Services is designated as the single State agency responsible for the overall administration of the federal Medicaid and CHIP programs (known in Delaware as the Delaware Healthy Children's Program). The day-to-day administration of these programs is the responsibility of the Division of Medicaid and Medical Assistance (DMMA).

Under the authority of a section 1115 Medicaid demonstration waiver approved by the Centers for Medicare and Medicaid Services (CMS) the State of Delaware created the Diamond State Health Plan (DSHP), a Medicaid managed acute care program, in January 1996. Both the categorically eligible population under Medicaid eligibility guidelines, as well as uninsured non-categorically eligible citizens with incomes below 100 percent of the Federal Poverty Level (FPL), are covered by this program. Enrollment in the DSHP was mandatory for all Medicaid and CHIP clients except those in long-term care and home- and community- based waiver programs, and dual eligibles (i.e., those eligible for both Medicare and Medicaid). In SFY 2009, approximately 111,000 or 68.6% of clients eligible for Medicaid and CHIP were enrolled in managed care via the Diamond State Health Plan.

Of the 128,098 DMMA clients enrolled in the Diamond State Health Plan in August 2009, 120,098 are enrolled with one of two commercial managed care companies. Over the years since the inception of the program, the State has had as many as four commercial managed care companies serving this program at the same time. Since July 2007, there have been two commercial managed care companies: Unison Health Plan of Delaware, Inc. and Delaware Physicians Care Inc (DPCI).

Diamond State Partners (DSP) is another health plan choice for clients in the Diamond State Health Plan, as an alternative to the commercial managed care companies. The State implemented Diamond State Partners in July 2002. This program is a State-operated PCCM model for which enrollment is currently capped at a maximum of 12,500 clients. As of August 2009, the program has 8,000 clients enrolled. Most are Medicaid clients, but some are children in the CHIP program. Eligibility and funding is the same as for families enrolled in the commercial managed care companies.

Delaware implemented the Delaware Healthy Children Program (DHCP – the State's CHIP program) in 1999. Currently, there are approximately 6,000 children enrolled in CHIP in families with incomes up to 200% of the poverty level. Families currently pay a small monthly premium per family to enroll their children in this program. All of these children are required to be in Delaware's managed care program, the Diamond State Health Plan. Most are enrolled with the commercial managed care companies. However, some are also enrolled in the State run Diamond State Partners managed care program. Premium collections from the families account for about 4% of DHCP program costs. The remainder of program costs is covered with Federal and State funds.

The following table explains the current structure of the Delaware's Medicaid and CHIP managed care programs:

Diamond State Health Plan (DSHP)		
	Medicaid Program	CHIP Program (Delaware Healthy Children's Program – DHCP)
	Funded by Federal and State Funds	Funded by Federal, State and Family Premium Funds
Managed Care Provider Choices	Covers Eligible Adults and Children Who Choose One Of The Following Managed Care Choices	Covers Only Children (not elig for Medicaid and family income under 200% of poverty) Who Choose One Of The Following Managed Care Choices:
Unison	X	X

DPCI	X	X
DSP (Diamond State Partners)	X	X

Delaware sought approval to operate its Medicaid program under a managed care delivery system in order to take advantage of managed care principles and a strong quality assurance program to revamp the way health care is delivered to Delaware's most vulnerable populations. By managing care and controlling costs, the State was able to reinvest program savings into Medicaid program eligibility expansion to cover adults in our State with incomes at or below 100 percent of the poverty level.

The commercial MCO's provide and coordinate a specified scope of health care services (the DSHP benefit package) for each enrollee in return for a monthly pre paid capitated payment made on a per member per month (PMPM) basis. By contracting with managed care organizations, DHSS has as its goals:

a. Reducing costs for delivering necessary health care to enrollees;
b. Assuring access for enrollees to all Medicaid covered services; and
c. Maintaining quality of health care with an emphasis on prevention.

The current commercial managed care contracts continue through the end of State Fiscal Year 2012 (June 30, 2012).

Most traditional Delaware Medicaid benefits are included in the MCO capitated benefit package for both Medicaid and CHIP enrollees with some notable exceptions. Pharmacy, non-emergency transportation, extended long-term care, most behavioral health benefits, and specialized services for children such as PPEC (Prescribed Pediatric Extended Care) are all excluded from the capitated benefit package. However, the non-capitated services referenced above continue to be available to DSHP recipients (both Medicaid and CHIP) as wrap around services and are covered by Medicaid and the State's CHIP program on a fee-for-service (FFS) basis. The MCOs coordinate participants' access to these Medicaid covered services that remain on a fee-for-service basis outside of the DSHP benefit package. There are no limits on benefits and no co-payments or deductibles except for a minor co-pay for prescriptions.

Per federal regulations, Delaware is required to provide independent enrollment broker services to assist members with the selection of and enrollment with a managed care organization. Delaware contracts this function to EDS. In addition, Delaware utilizes the services of a contracted fiscal agent (EDS) to process all fee-for-service claims, issue monthly capitation payments to the commercial managed care organizations, receive and store encounter claims from the managed care companies and collect premiums from families who enroll their children in the CHIP program.

THE CHIP LOOK-ALIKE PROGRAM

The Delaware Department of Health and Social Services (hereafter referred to as "DHSS" or "the DHSS") seeks to create a CHIP Look-Alike program for all interested families in the state who have incomes above the current eligibility cut off of 200% of the federal poverty level. This planned CHIP Look-Alike program is the result of legislative action. House Bill 139 was passed during the recent session of the 145th General Assembly and signed into law. The following is the text of that law:

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Section 9909, Chapter 99, Title 16 of the Delaware Code by re-designating existing sections (j) through (p) as sections (k) through (q), and adding the following new section (j), which shall read as follows:

"(j) (1) The provision of health care insurance under CHIP shall be extended to eligible children under the age of nineteen (19) whose families have personal incomes above 200% of the Federal Poverty Level (FPL), as determined pursuant to 42 U.S.C. § 1397jj(c)(5).

(2) For an eligible child whose family income is greater than 200% of the FPL, the family may purchase a healthcare benefit package, determined by DHSS and subject to any necessary approval under federal law, that provides benefits identical to those provided to an eligible child covered under this section.

(3) To be eligible for coverage under CHIP where family income is greater than 200% of the FPL, a child over two (2) years of age must have been uninsured for a continuous period of not less than three (3)

consecutive months immediately preceding enrollment in CHIP unless:

a. The child's parent is eligible to receive benefits pursuant to the State's unemployment compensation laws, as set forth in Title 19;

b. The child's parent was covered by a health insurance plan, a self-insurance plan or a self-funded plan and involuntarily lost coverage; or

c. A child is transferring from one government-subsidized health care program to another.

(4) DHSS shall have the authority to establish and adjust the levels of co-payments, premiums, and deductibles for children enrolled under this subsection for the purpose of ensuring that the State cost of the plan does not exceed funds specifically appropriated for purposes of this subsection.

SYNOPSIS

This Bill extends Delaware's Childrens' Health Insurance Program (CHIP) to include reduced-cost health insurance coverage for children of families with personal incomes above 200% of the Federal Poverty Level. However, a cost-sharing program is to be implemented under CHIP whereby payments, as determined by DHSS, must be paid on behalf of the child for such care; notwithstanding the above, the cost-sharing provision of the bill is designed to have the new program impose no cost whatsoever on the State unless funds are specifically appropriated for it.

Amend House Bill No. 139 by adding the following immediately after current line 19:

"Section 2. This Act shall take effect on January 1, 2010. By December 1, 2009, the Secretary of Health and Social Services shall report to the Office of Management and Budget and the Controller General's Office the co-payments, premiums, and deductibles to be charged under Section 1."

SYNOPSIS

The purpose of this Amendment is to ensure that DHSS has sufficient time to establish the premium and, thereby, ensure that there is no cost to the State of Delaware by way of this program.

As stated in the Synopsis above, the CHIP Look-Alike program cannot result in any cost to the state. As a result of this requirement, the DHSS has determined that it cannot simply fold the expanded group into the existing program. Although there are some minimal premiums paid by families in the current program, the cost is overwhelmingly covered by state and federal funds.

Therefore, the state is considering the option of contracting out the entire program for the expanded group. The new stand-alone program would have to conform to all the requirements of H.B. 139, especially including health insurance coverage of benefits identical to those provided to an eligible child covered under the existing Delaware CHIP program (with minor exceptions, the CHIP benefit is identical to the Medicaid benefit in Delaware).

Under this approach, a likely vendor would be an insurer utilizing a managed care plan including an affiliate or subsidiary of the insurer as a co-vendor. Such a vendor would use appropriate cost-management methods and managed health care techniques and other appropriate medical cost management methods. The vendor would be expected to:

- Develop materials as necessary to conduct marketing and outreach activities on behalf of the program.
- Determine initial eligibility for coverage, redetermine it annually and enroll eligible children.
- Transfer applicants and enrollees, as required.
- Provide translation services for children or parents needing them to communicate with a healthcare provider.
- Determine the level of monthly premium payment necessary to cover all program costs.
- Collect the monthly premium from parents of children enrolled in the program.

- Contract with and maintain an adequate network of qualified providers statewide to provide primary, preventive, and specialty health care.
- Require collection of co-payments at point of service.
- Provide all required health care services to each enrollee,
- Implement evidence-based Wellness, Obesity, and Disease Management Programs, including chronic care management and medical homes.
- Develop written materials as necessary and provide health education to parents of enrollees with emphasis on health promotion, wellness, and healthy lifestyles and practices.
- Provide customer service.
- Use all reasonable coordination of benefits and subrogation efforts to recoup funds that should rightly have been paid by another entity.
- Perform quality assurance tasks (including, but not limited to, monitoring quality of care and health outcomes, conducting performance improvement projects, and participation in Payment Error Reduction Management requirements).
- If requested, provide the DHSS with enrollee-level electronic data files regarding access, claims costs, and utilization of all medical, dental, pharmaceutical, and behavior health and substance abuse services.
- Recommend and implement measures to contain costs.
- Plan, manage and administer the program including any necessary actuarial and rate setting tasks.
- Establish any necessary policies and procedures.
- Handle all provider relations issues and customer service.
- Issue some type of insurance card to participating families.
- Provide a mechanism for providers to determine up to the minute eligibility status.
- Set premiums, co-payments and deductibles for the program that the vendor determines would be sufficient to cover all program costs including the vendor's administrative costs.
- Claims processing. Receive and pay all bills from all providers (this would include pharmacy and other services which are paid by DHSS as fee-for-service wrap around costs in its Medicaid and CHIP programs).
- Coordinate with DHSS to determine if applicants could be eligible for the existing CHIP or Medicaid program.
- Provide monthly and annual reports to DHSS and the Delaware General Assembly.
- Perform quality assurance tasks (including, but not limited to, monitoring quality of care and health outcomes).
- Comply with the Privacy and Security requirements under HIPAA.
- Comply with all applicable state and federal laws and regulations.

RFI RESPONSES

The DHSS is interested in receiving responses especially from health insurance entities as well as any other interested parties. DHSS is interested in receiving any thoughts, ideas, comments or suggestions concerning the feasibility and financial viability of the proposed Look-Alike of the CHIP program. Respondents to this RFI are not obligated in any way to participate now or in the future in the proposed CHIP Look-Alike program. If a respondent to this RFI chooses to participate in a future RFP, the respondent's participation will not be limited by any information provided in their response to the RFI. Delaware intends to use the responses to help improve the design of the program.

Through this RFI, the DHSS wants to determine:

1. If there is any interest from the private sector in serving the target population.
2. If any private sector insurance entity has experience serving the target population or a similar population possibly in another state.
3. If a private sector insurance entity is aware of any opportunity to combine enrollees in the proposed Delaware program into another insurance product with a larger risk pool.
4. If any private sector insurance entity would be able to share any thoughts about the likely health care utilization of potential enrollees.
5. In particular, the DHSS would like to know an approximate monthly per child premium amount that a private sector insurance entity might charge for the proposed program (as well as co-pays and deductibles that may factor into the premium amount.)
6. If a potential vendor has experience with a similar program, DHSS would like to get the vendor's estimate of the numbers of children who might be enrolled in the new program.
7. DHSS would like to know of any other significant factors, not already referenced herein, that would have to be considered in establishing a premium for the proposed program.
8. DHSS would like to know of any program design modifications that a private insurance entity would require the state to adopt before considering possible participation in the proposed program.

The DHSS is looking for written responses, but there is no particular format required for responses. Responses can be sent via US mail, other mail delivery services to Frank O'Connor at the address on the front page, or as an e-mail or e-mail attachment to: frank.oconnor@state.de.us. DHSS will be considering all responses received through November 13, 2009.

SCOPE OF SERVICES FOR THE PROPOSED CHIP LOOK-ALIKE PROGRAM

(NOTE: TO BE CLEAR, DHSS IS NOT ASKING VENDORS TO SUBMIT PROPOSALS TO IMPLEMENT THIS PROGRAM. THE FOLLOWING IS ONLY BEING PROVIDED TO INFORM RESPONDENTS TO THIS RFI OF THE SCOPE OF THE PROGRAM BEING ENVISIONED FOR DELAWARE)

The following describes in more detail the type of program envisioned by the State. These requirements are similar to a recent RFP issued by the Commonwealth of Pennsylvania for their CHIP program and have been modified as necessary to fit Delaware's requirements. If Delaware were to contract for a full risk stand-alone CHIP Look-Alike program, these are the kinds of requirements the State would expect any vendor interested in serving the Delaware CHIP Look-Alike population to meet:

Monthly premium rates will be determined by the vendor and will be based on an actuarially sound and adequate methodology. The premium rate would be designed to provide the vendor with a prospectively determined monthly amount sufficient to meet all program costs including health care service costs as well as administrative costs. This could potentially include some administrative costs incurred by the State in connection with this program. The vendor would be expected to demonstrate that the proposed premium rate(s) is (are) actuarially sound.

Since H.B. 139 allows for co-pays and deductibles, vendors would be required to specify any cost sharing or deductibles that factor into their premium rates such as for the following:

- Co-payment of $xx for primary care physician visits (except for well child visits);
- Co-payment of $xx for specialist visits;
- Co-payment of $xx for emergency room. Co-payment is waived if admitted;
- Co-payment of $xx for generic/brand-name retail prescription drugs (30 days supply);
- Co-payment of $xx for generic/brand-name mail-order prescription drugs (90 days supply).
- Any variations on the above or other co-pays or deductibles the vendor may wish to recommend.

Covered Health Care Benefits And Administrative Costs

In establishing a monthly premium amount, vendors would have to consider the cost to cover all of the following medically necessary (as defined by DHSS) services and administrative costs (the service categories below represent the major areas of utilization

for program enrollees). The vendor would be required to provide all services described below.

Benefit Package in General Would Cover:

- Preventive care/well-child visits;
- Diagnosis and treatment of illness or injury, including all medically necessary covered services related to the diagnosis and treatment of sickness or injury and other conditions provided on an ambulatory basis, such as laboratory tests, x-rays, wound dressing, and casting to immobilize fractures;
- Injections and medications;
- Inpatient hospitalization without limitation
- Outpatient hospital services;
- Emergency accident and emergency medical care;
- Emergency, preventive, and routine dental care;
- Emergency, preventive, and routine vision care;
- Emergency, preventive, and routine hearing care; and
- Prescription drugs.

(a) Primary and Preventive Care Services: This includes well-child care in accordance with the schedule established by the American Academy of Pediatrics and the services related to those visits, including, but not limited to immunizations, health education (to include all types of tobacco use prevention and cessation), tuberculosis testing, and developmental screening in accordance with the routine schedule of well-child visits. Care must also include a comprehensive physical examination, including x-rays, if necessary, for any child exhibiting symptoms of possible child abuse. Allergy diagnosis and treatment is also covered.

(b) Injections and Medications: Includes all injections and medications provided at the time of the office visit or therapy and outpatient surgery performed in the office, a hospital, or freestanding ambulatory service center, including immunizations and the immunizing agents, which, as determined by the DHSS to conform with standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. DHHS of Health and Human Services, and anesthesia services when performed in connection with covered services, including emergency services.

(c) Routine Gynecological Services: Includes one routine annual gynecological examination, including a pelvic examination and clinical breast examination and one routine Papanicolaou smear per year for all female enrollees who are sexually active. Also includes counseling, education and related services to prevent and address the consequences of at-risk behaviors related to sexually transmitted diseases (STDs) and pregnancy. Each enrollee may utilize her

primary care physician or she may directly choose any participating professional provider delivering gynecological services without referral.

(d) Obstetrical Services: Includes prenatal and postnatal care, and complications of pregnancy and childbirth. A referral is not required when the maternity care is provided by a network obstetrician, network Licensed nurse-midwife, or a network PCP. Mothers and infants can remain in the hospital for 48 hours after a normal delivery or 96 hours after a Cesarean delivery.

(e) Newborn Care: Includes the provision of benefits for a newborn child of an enrollee for a period of thirty-one (31) days following birth. Includes routine nursery care, prematurity services, preventive/well-child health care services, newborn hearing screens, and coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(f) Maternity Home Health Care Visit: Enrollees are covered for one (1) maternity home health care visit provided at their home within 48 hours of discharge when the discharge from a facility provider occurs prior to: (a) 48 hours of inpatient care following a normal vaginal delivery or (b) 96 hours of inpatient care following a Cesarean delivery. The visit includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance of any necessary maternal and neonatal physical assessments.

(g) Family Planning Services: Includes, but is not limited to, birth control pills, injectibles, transdermals (patches), and insertion and implantation of contraceptives, including devices and sterilization.

(h) Abortions: Abortions are only covered, as specified in 42 C.F.R. §457.475 in the following cases:

(1) A physician has certified that the abortion is necessary to save the life of the mother; and

(2) The abortion is performed to terminate a pregnancy resulting from an act of rape or incest reported within 72 hours from the date when the female first learned she was pregnant.

Elective abortions are not covered. Services rendered to treat illness or injury resulting from an elective abortion are covered.

(i) Diagnostic, Laboratory, and X-ray Services: Includes all laboratory and x-ray services, EKGs, and other diagnostic services related to the diagnosis and

treatment of sickness and injury provided on an ambulatory or inpatient hospital basis.

(j) Diabetic Treatment, Equipment, and Supplies: Includes blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar, orthotics, and outpatient self-management training and education, including information on proper diets.

(k) Specialist Physician Services: Includes medical care in any generally accepted medical specialty or subspecialty. Vendors may require prior authorization for specialty services and must identify the service(s) and medical items to be prior authorized. The DHSS must be notified in writing of any changes in services or medical items that require prior authorization.

(l) Consultations: Includes second opinion consultations to determine the medical necessity of elective surgery or when an enrollee's family desires another opinion about medical treatment.

(m) Surgical Services: Surgery performed for the treatment of disease or injury is covered on an inpatient or outpatient basis. Cosmetic surgery intended solely to improve appearance, but not to restore bodily function or to correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes (excluding surgery resulting from an accident) is not covered.

(n) Inpatient Hospitalization: Includes semi-private room and board accommodations; private accommodations when medically necessary; general nursing care; use of intensive or special care facilities when medically necessary; diagnostic and therapeutic radiological procedures; use of operating room and related facilities; drugs, medications, and biologicals; laboratory testing and services; pre- and post-operative care; special tests when medically necessary; therapy services, oxygen, anesthesia, and anesthesia services; and any other services normally provided by the vendor relating to inpatient hospitalization and skilled nursing inpatient care.

(o) Skilled Nursing Facility Services: Medically necessary skilled nursing and related services are covered up to 30 days on an inpatient basis in semi-private accommodations for patients requiring skilled nursing services, but not requiring a hospital level of care.

(p) Organ Transplants: Includes transplants that are medically necessary and not considered to be experimental or investigative for a recipient who is an enrollee. Benefit also includes immunosuppressants.

(q) Outpatient Hospital Services: Includes medical services, nursing, counseling or therapeutic treatment, or supplies received from an approved health care facility while not an inpatient.

(r) Home Health Care: This includes benefits such as nursing services; private duty nursing services; physical, speech and occupational therapies; medical and surgical supplies; oxygen and its administration; home medical equipment; and well mother/well baby care following release from an inpatient maternity state.

(s) Hospice Care: For the terminally ill, hospice care requires preauthorization and certification by a physician that the member has a terminal illness. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less. Services include palliative (pain relief) and supportive services; professional services of an RN or LPN, medical care provided by a physician affiliated with the hospice agency, therapies except for dialysis treatments, medical and surgical supplies, home medical equipment, prescribed drugs, respite care, oxygen and its administration, medical social service consultations, home health aides, and family counseling.

(t) Mental Health Services:

- Inpatient Mental Health services
- Outpatient Mental Health Services. Includes psychological testing; consultations; individual, group or family therapy; targeted mental health case management and resource coordination; and prescription drugs.

(u) Drug and Alcohol Abuse Treatment includes:

(1) Inpatient Detoxification: Services provided either in a hospital or in an inpatient non-hospital facility and is licensed as an alcoholism and/or drug addiction treatment program. The following services are covered:

- Lodging and dietary services;
- Physician, psychologist, nurse, certified addictions counselor and trained staff services;
- Diagnostic x-ray;
- Psychiatric, psychological and medical laboratory testing; and
- Drugs, medicines, equipment use, and supplies.

(2) Non-Hospital Residential Treatment: Services provided in a facility which meets minimum standards as an alcoholism or drug addiction treatment program. The following services are covered:

- Lodging and dietary services;
- Physician, psychologist, nurse, certified addictions counselor and trained staff services;
- Family counseling and intervention; and

• Psychiatric, psychological, and medical laboratory tests.

(3) Outpatient Services: Services provided in a facility licensed as an alcoholism or drug addiction treatment program. The following services are covered:

• Physician, psychologist, nurse, certified addictions counselor and trained staff services;
• Rehabilitation therapy and counseling;
• Family counseling and intervention;
• Psychiatric, psychological and medical laboratory tests; and
• Drugs, medicines, equipment use, and supplies.

(v) Medical Foods: Includes medical foods and prescribed nutritional formulas used to treat Phenylketonuria (PKU) and related disorders.

(w) Emergency Medical and Accident Services (including emergency transportation).

(x) Prescription Drugs: Includes any substance taken by mouth, injected into a muscle, the skin, a blood vessel, or a cavity of the body, or applied topically to treat or prevent a disease or condition, including over-the-counter products, dispensed by order of a health care provider with applicable prescriptive authority. Vendors may use a closed or restrictive formulary provided it meets the minimum clinical needs of CHIP enrollees. A mail order or designated pharmacy process can be used for maintenance prescriptions.

(y) Emergency, Preventive, and Routine Dental Care: Includes diagnostic, preventive, and restorative care, endodontics, periodontics, prosthodontics, maxillofacial prosthetics (by prior authorization), adjunctive general services, and medically necessary orthodontic care, but does not include cosmetic dental care.

(z) Oral surgery for removal of partially or fully impacted wisdom teeth.

(aa) Emergency, preventive, and routine vision care: Includes the cost of exams, corrective lenses, frames, and medically necessary contacts.

(bb) Emergency, preventive, and routine hearing care: Includes the cost of examinations and hearing devices.

(cc) Prosthetics Appliances: Includes the purchase of prosthetic devices and supplies to replace all or part of an absent body part or to restore function to permanent malfunctioning body organs. The benefit extends to the fitting and necessary adjustment of prosthetic devices. Replacements are covered only when

the replacement is deemed medically necessary and appropriate and due to the normal growth of the child.

(dd) Orthotic Devices: Includes the purchase, fitting, necessary adjustment, repairs, and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part. Replacements are covered only when the replacement is deemed medically necessary and appropriate and due to the normal growth of the child.

(ee) Durable Medical Equipment and Assistive Technology: Includes rental (not to exceed the total cost of purchase) or the purchase of durable medical equipment or AT which is required for therapeutic use and is appropriate for home or school use.

(ff) Outpatient Therapy Services – Includes the Following Services Necessary For Rehabilitation and For Developmental Delays :
• Speech, occupational, and physical therapy
• Chemotherapy, dialysis, respiratory, and radiation therapy (unlimited).

Preventive/Well-Child Health Care Services

The vendor is required to place special emphasis on preventive/well-child health care services. Periodic health screens should be performed on all enrollees to identify health and developmental problems. These screens should be in accordance with the latest age-appropriate periodicity schedule, as recommended by the American Academy of Pediatrics. These screens, and the services related thereto, include, but are not limited to:

- A comprehensive health and developmental history, including health education, nutrition, tobacco use and developmental assessment;
- An unclothed physical exam;
- Laboratory tests;
- Vision testing;
- Hearing testing;
- Newborn hearing screens;
- Tuberculosis testing;
- Immunizations;
- Dental screening [oral exam by PCP as part of comprehensive examination required before age three (3)];
- Blood lead levels screening of all children at ages one and two years and for all children aged three through six without a confirmed prior lead blood test consistent with current DOH and Centers for Disease Control (CDC) standards.71

- Obesity prevention, including office visits to review results of the mandatory Growth Screening Assessment provided by the child's school; and
- All other medically necessary screening services.

Emergency Room (ER) Services

Emergency providers may initiate the necessary intervention to stabilize the condition of the patient without seeking or receiving prior authorization by the vendor.

Differently Accessed Services

The PCP must furnish primary care to enrollees who are enrolled with them and serve as gatekeepers for access to most other types of services. However, there are some services that can be accessed without a referral from the PCP, including, but not limited to, gynecological, vision care, and dental care, providing the enrollee obtains the services from providers participating in their vendor's provider network.

Examinations to Determine Abuse or Neglect

Vendors must ensure that CHIP enrollees under evaluation for suspected child abuse or neglect by the Delaware Division of Family Services and who present for physical examinations for determination of abuse or neglect will receive such services. These services will be performed by trained examiners in a timely manner according to the Delaware Child Welfare regulations.

Administrative Responsibilities

1. Prior Authorization of Services

The vendor may require prior authorization of a service. If electing to require prior authorization, the vendor must establish and maintain written policies and procedures that may be reviewed by the DHSS at its discretion. The policies and procedures must include an expedited review process to address situations when an item or service must be provided on an urgent basis. Vendors must demonstrate how written policies and procedures for requests for prior authorization comply and are integrated with the enrollee notification requirements and enrollee grievance and appeal procedures.

2. Executive Management Functions

The vendor must have in place sufficient administrative staff and organizational components to carry out the usual and customary administrative functions and must be staffed by qualified persons in numbers appropriate to the vendor's size of enrollment. The vendor may combine functions or split the responsibility for a function across multiple insurance products as long as it can demonstrate that the duties of the functions are fulfilled. Similarly, the vendor may contract with a third party (subvendor) to perform one or more of the functions. Each Vendor's personnel must

have appropriate training, education, experience, and orientation to fulfill the requirements of their positions.

3. Subcontracts

The vendor may enter into subcontracts to fulfill its obligations under this contract. All subvendors utilized to perform part or all of the vendor's responsibilities shall provide the same level of services and procedural protections set forth in the contract with the vendor, this RFP, and the successful proposal.

4. Subcontracts with Behavioral Health Organizations (BHOs)

If the vendor that subcontracts with BHOs, the vendor must provide a copy of their subcontracts with this proposal. The vendor will be required to list the names of its behavioral health and substance abuse providers in their provider directories in addition to any specific access number the vendor might utilize. The DHSS will require submission of the vendor's annual report on their BHO providers, if applicable, as part of the readiness review and routine reporting requirements throughout the contract period.

5. Records Retention and Availability

The vendor must agree to maintain records relating to the program services and expenditures, including reports to the DHSS and source information used in preparation of these reports. These records include, but are not limited to, financial statements, records relating to quality of care, and medical claims. Such records must be maintained in electronic imaging format and must be legible and readily retrievable and available for review, audit, or evaluation by authorized DHSS personnel or their representatives. The vendor is required to maintain all source and actual records for a minimum of five (5) years from the expiration date of the contract period or as otherwise required by law, except that if an audit is in progress or audit findings are yet unresolved, records shall be kept until all tasks are completed.

- **Medical Claims**. The vendor must agree to comply with all standards for practice and medical record-keeping. The vendor shall retain enrollee-level medical claims information and other evidence of medical utilization as set forth above.

- **Financial Records.** The vendor shall maintain books, records, documents, and other evidence pertaining to all revenues (including receipt of premium payments received from enrollees), expenditures, and other financial activity pursuant to this contract as set forth above.

- **Audit.** The vendor shall, at its own expense, make all records available for audit, review, or evaluation by the DHSS and its designated representatives. Access shall be provided as directed by the DHSS. During the contract and record retention period, these records shall be available at the vendor's chosen

location, subject to approval of the DHSS. The vendor must fully cooperate with any and all reviews and/or audits by the DHSS and its designated representatives, by assuring that appropriate employees and involved parties are available for interviews relating to reviews or audits. All records to be sent by mail shall be sent to the requesting entity in the form of accurate, legible paper copies, unless otherwise indicated, within fifteen (15) calendar days of such request and at no expense to the requesting entity. Such requests made by the DHSS shall not be unreasonable.

The vendor must have written policies and procedures for storing this information.

6. Fraud and Abuse

The vendor is required to establish written policies and procedures for the detection and prevention of fraud and abuse that may be committed by providers within their networks, by enrollees, or by the vendor's employees. The vendor will be required to provide copies of its fraud detection and prevention policies and procedures when requested to do so by the DHSS. The vendor must designate appropriate staff to be responsible for the proactive detection, prevention, and elimination of instances or patterns of fraud and abuse involving services to enrollees. The vendor must submit to the DHSS annual statistical and narrative reports which relate to its fraud detection and sanctioning activities where fraud has been confirmed.

Fraud and abuse detection activities must be compatible with the requirements of appropriate law enforcement agencies responsible for fraud and abuse detection and prosecution. The vendor shall have an affirmative responsibility to refer information or suspected fraudulent activities of subvendors, providers, and enrollees to relevant law enforcement agencies and shall cooperate fully with the investigation and prosecution by appropriate law enforcement agencies.

The vendor shall advise all subvendors of the prohibitions against fraudulent activities relating to their involvement with the program. The vendor shall also, as a written provision in all contracts with providers, advise all providers of the prohibitions against the submission of false or fraudulent statements and claims related to the program.

In the event of confirmation of successful prosecution of a vendor and/or subvendor or provider related to involvement with the program, the vendor shall take action to suspend or terminate the subvendor or provider. The vendor shall notify the DHSS immediately of any action being taken against a subvendor or provider because of successful prosecution for fraudulent activities. Failure to report such information to the DHSS shall constitute a default of the contract.

In the event of successful prosecution of a vendor for fraudulent activities relating to the program, the DHSS shall consider the vendor in default of the contract. The vendor

shall comply with the Exclusion Program of the United States DHSS of Health and Human Services, Office of Inspector General, §1128 et seq of the Social Security Act (42 U.S.C. §1320a-7 et seq.)

7. Patient Safety

The vendor must have policies and procedures, in accordance with nationally recognized standards, that describe its efforts and programs related to patient safety and the reduction of medical errors. Vendors will be required to submit their policies and procedures at a future date to be determined by the DHSS. The vendors is asked to summarize the most current reports or studies (or attach a copy of the report or study) on the results of the Vendor's efforts to reduce medical errors (e.g., reduction in the number of hospital-acquired infections; reduction in the number of readmissions to hospitals due to surgical errors or errors in post-surgical care; reductions in preventable asthma admissions; inappropriate prescribing of antibiotics or other medications). The DHSS may, at a future date, establish protocols for reporting data on medical errors for the purpose of establishing quality improvement initiatives. Vendors will be required to comply with any such protocols once established.

8. Disease Management

The DHSS requires vendors to provide enrollees with access to disease management and chronic care management programs.

9. Pharmacy Requirements

The vendor is must use the Delaware Medicaid formulary but may require prior approval as a condition of coverage for an outpatient prescription drug. If prior approval is required, the vendor shall provide a response within twenty-four (24) hours from the time the request is made. In the event, for whatever reason, this deadline cannot be met, the vendor shall make provisions to allow the dispensing of at least a seventy-two (72) hour supply of the drug.

Under no circumstances shall the vendor either direct or permit the therapeutic substitution of a prescription drug by a pharmacist without explicit authorization from the licensed prescriber.

A. Pharmacy Benefit Manager (PBM)

The vendor may use a PBM to process prescription claims. The vendor shall indicate the intent to use a PBM, identify the proposed PBM subcontract, and the ownership of the proposed PBM subvendor. If the PBM is owned wholly or in part by a retail pharmacy provider, chain drug store, or pharmaceutical manufacturer, the vendor shall submit a written description of the assurances and procedures that will be put in place by the proposed PBM subvendor, such as an independent audit, to assure confidentiality of proprietary information.

B. Drug Utilization Review (DUR) Program

The vendor must have written policies and procedures regarding DUR that must be provided to the DHSS upon request. As part of this, the vendor must assure that prescriptions for outpatient drugs are appropriate, medically necessary, and are not likely to result in adverse medical results.

In addition, the vendor must identify and reduce the frequency of patterns of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care among physicians, pharmacists, and enrollees associated with specific drugs as well as:

Potential and actual adverse drug reactions;
Therapeutic appropriateness;
Over-utilization and under-utilization;
Appropriate use of generic products;
Therapeutic duplication;
Drug disease contraindications;
Drug interactions;
Incorrect drug dosage or duration of drug treatment;
Drug-allergy interactions; and
Clinical abuse/misuse.

The vendor must have a procedure in place to assess drug use against predetermined therapeutic drug criteria standards. These standards must be consistent with medical practices that have been developed by unbiased, independent experts through an open professional consensus process. This procedure must also include an ongoing review for current drug criteria standards. All drug criteria standards must be submitted to the DHSS upon request.

The vendor must:

Have planned methodologies and mechanisms for prospective DUR at the point of sale or point of distribution before each prescription is filled or delivered to the enrollee;
Have a process for communicating with and counseling enrollees based on standards established by state law and for the maintenance of enrollee profiles; and
Have procedures for retrospective DUR through mechanized drug claims processing and an information retrieval system.

In no case shall a vendor's DUR program provide any financial or other incentive to a pharmacist for encouraging the physician to change his/her prescription order. Changes are accepted only when warranted by clinical reasons of enrollee safety and approved efficacy.

9. Provider Networks

A. Adequacy

The vendor must establish and maintain adequate statewide provider networks to serve all eligible children who are or may be enrolled, to include, but not be limited to: hospitals, children's tertiary care hospitals, specialty clinics, trauma centers, facilities for high-risk deliveries and neonates, pediatricians, specialists, physicians, pharmacies, dentists, substance abuse treatment facilities, emergency transportation services, rehabilitation facilities, home health agencies, certified hospice providers and DME suppliers in sufficient numbers and geographic dispersions to make available all services in a timely manner

.

A plan that has no participating health care providers within the approved service area available to provide covered health services shall arrange for and provide coverage for services provided by a nonparticipating health care provider. The plan shall cover the non-network services at the same level of benefit as if a network provider had been available.

The vendor will have a contracted and credentialed provider network to meet the needs of its enrolled population.

The vendor must ensure that its provider network is adequate to provide its enrollees with access to quality enrollee care through participating professionals, in a timely manner, and within a reasonable travel time and distance. Upon request from the DHSS, the vendor must supply geographic access maps using enrollee-level data detailing the number, location, and specialties of its provider network to the DHSS in order to verify accessibility of providers within its network in relation to the location of its enrollees. The DHSS may require additional numbers of specialists and ancillary providers should it be determined that geographic access is not adequate. The vendor must also have a process in place which ensures that the vendor knows the capacity of its network PCP panels at all times and have the ability to report on this capacity.

In addition, the vendor must consider the following in establishing and maintaining its provider network:

- The anticipated CHIP Look Alike program enrollment;
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific CHIP Look-Alike populations to be serviced by the vendor;
- The number and types, in terms of training, experience, and specialization, of providers required to furnish the contracted CHIP Look-Alike services;

- The number of network providers who are not accepting new CHIP Look-Alike patients, and
- The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location provides physical access for enrollees with disabilities.

The vendor cannot discriminate against CHIP Look-Alike enrollees by offering them access to physician services which are more limited than the access offered to commercial enrollees. For example, a plan may not specifically close a practice to CHIP enrollees if the practice is open to commercial enrollees.

B. Cultural Competence

A portion of the individuals served by the CHIP Look-Alike program will be minorities, including African-Americans, Asians, Hispanics, and others. Health care initiatives, outreach, and educational activities should be sensitive to the health care needs of the culturally and ethnically diverse children served.

The vendor is encouraged to be culturally sensitive and to establish provider networks that represent the diversity of its enrollees and their neighborhoods. The vendor is to provide a list of languages spoken by vendor's physicians (and other providers if known).

C. PCP / Medical Home Responsibility

The PCP/Medical Home must serve as the enrollee's initial and most important point of contact regarding health care needs (except for emergencies or direct access benefits). As such, PCP responsibilities must include at a minimum:

- Providing primary and preventive care, acting as the enrollee's advocate, and providing, recommending, and arranging for care;
- Maintaining continuity of each enrollee's health care, participating in or coordinating with an overall chronic care management team, where appropriate;
- Making referrals for specialty care and other medically necessary services, both in and out of plan;
- Maintaining a current medical record for the enrollee, including documentation of all services provided to the enrollee by the PCP/Medical Home, as well as any specialty or referral services; and Providing office hours accessible to enrollees for a minimum of twenty (20) hours per week and be available directly or through on-call arrangements with other qualified, plan-participating PCPs/Medical Homes, twenty-four (24) hours per day, seven (7) days per week, for urgent and emergency care.

D. Certified Registered Nurse Practitioner (CRNP) as a PCP / Medical Home

The DHSS encourages the vendor to fully utilize CRNPs to serve the CHIP Look Alike program enrollees and include them in their panels of providers.

E. Standing Referrals / Specialist as a PCP / Medical Home

An enrollee with a life-threatening, degenerative or disabling disease or condition shall have access to a specialist as a PCP/Medical Home. An enrollee shall have the right to request and receive an evaluation, and if the plan's standards are met, the enrollee shall receive either a standing referral to a specialist with clinical expertise in treating the disease or the designation of a specialist to provide and coordinate the enrollee's primary and specialty care.

F. PCP / Medical Homes

Vendors are encouraged to establish PCP/Medical Home teams that include Licensed Nurse-Midwives, CRNPs, and/or physician assistants, if a part of the network, who serve as the primary contact for the enrollee. The vendor must organize its PCP/Medical Homes so as to ensure continuity of both medical and non-medical care to enrollees.

G. Physician Specialists

No vendor is required to maintain specific enrollee-to-specialist provider ratios. However, the vendor must agree to provide adequate access to physician specialists for PCP/Medical Home referrals and to employ or contract pediatric specialists in sufficient numbers to ensure specialty services can be made available in a timely and geographically accessible manner, as determined by the DHSS.

H. Federally Qualified Health Centers (FQHCs) and Community Health Center (CHC) Look-alikes

The vendor must include FQHCs and CHCs in provider networks or as a source of primary care. If the Vendor's primary care network includes FQHCS and CHCs, these sites may be designated as PCP sites.

I. Credentialing and Re-credentialing

The vendor has the authority to selectively contract with providers and to select only a certain number in a geographic area in order to offer a greater volume of enrollees to each provider, negotiate cost-effective rates of payment, and define standards of care. Therefore, vendors render the final decision. The provider cannot appeal the vendor's credentialing and network decision to the DHSS unless the denial violates the requirements listed above.

J. Provider Terminations

The vendor has the authority to terminate providers as specified in their provider contracts.

10. Provider Services

The vendor must provide Provider Services functions. Provider Services functions will be required to be operated at least during regular business hours (Monday through Friday). Arrangements must be made to deal with emergency provider issues on a twenty-four (24) hour, seven (7) day-a-week basis. These Provider Services functions include, but are not limited to, the following:

- Assisting providers with questions concerning enrollee eligibility status;
- Assisting providers with vendor prior authorization and referral procedures;
- Assisting providers with claims payment procedures;
- Handling provider complaints;
- Facilitating medical record transfer among providers as necessary;
- Providing to PCPs, at least on a monthly basis, a list of enrollees who are under their care, including identification of new and deleted enrollees;
- Providing comprehensive enrollee profiles to PCPs reflecting encounters and claims processed for each enrollee; and
- Coordinating with out-of-plan services.

11. Appointment Standards

The vendor must have adequate health care available in a timely and accessible manner through its network providers. In addition, the vendor should promulgate appointment standards in accordance with accepted medical practice, and to verify that its panel of primary care physicians can accept and serve plan patients in accordance with a minimum level of quality.

12. Quality Management And Utilization Management Program (QM/UMP)

1. Objectives

(a) Quality Management (QM)

Quality is when the care and services meet or exceed the expectations of the client or consumer and when patients receive all recommended evidenced-based care for their health status. Although expected outcomes for each person may be different, each believes the amount of their relief was directly related to the amount of quality care rendered by the health care provider. In addition, the health care provider strives to reduce the occurrence of undesired outcomes given the current state of their professional knowledge. The DHSS is committed to requiring that individuals enrolled in the program

receive quality health care services that are delivered in a cost effective manner and to continuously improving quality of care through:

(1) Proactive interventions designed to identify and address problems relating to access and quality of care.
(2) Regular and routine analysis and reporting of collected data.
(3) Development of interventions which are designed to continuously meet and improve upon established standards of care.
(4) Ongoing evaluation and assessment of the overall clinical care provided.

(b) Utilization Management Program (UMP)

The UMP is the planning, organizing, directing, and coordinating of health care resources to provide medically necessary, timely, and quality health care in the most cost effective manner. The DHSS is committed to requiring that individuals eligible for and enrolled in the program receive medically necessary and appropriate care through a planned program of UM and review that:

(1) Provides for medical case management systems that are accountable to enrollees and providers and manage care across the service continuum.
(2) Assesses the medical necessity and appropriate level of care of services.
(3) Identifies instances and patterns of both over-utilization and under-utilization and analyzes how UMP activities affect the quality of care provided.
(4) Provides for the regular and routine analysis and reporting of collected data.

(c) Complaint and Grievance Procedures

The vendor is required to have written policies and procedures for processing complaints and grievances. The vendor must link its complaint and grievance system to its Quality Management and Utilization Management Program (QM/UMP) for review, corrective action, resolutions, follow-up, and provider re-credentialing decisions. The vendor must have a data system in place capable of processing, tracking, and trending all complaints and grievances.

13. Customer Service

The DHSS is committed to meeting the needs of customers by providing the information and assistance that they need in applying for coverage and receiving health care services. In addition to providing the health care services described in the benefit package to all enrollees, customer service is comprised of the following components and requirements:

A. Outreach

The vendor is required to conduct outreach activities to identify and inform potentially eligible families and children of the availability of the program for purposes of enrollment into the program. The vendor shall develop and submit to the DHSS for approval an Outreach Plan that describes the strategies to inform potential enrollees about the program and to encourage enrollment. The vendor will be required to provide periodic reports regarding outreach efforts, including results of the efforts. A portion of the individuals served by the program will be minority and other underserved populations. Outreach activities must be sensitive to the culturally and ethnically diverse persons served.

B. Enrollee Help Line

The vendor is required to maintain a toll-free help line available to all applicants and enrollees for the purpose of providing information and for problem resolution related to eligibility and enrollment issues. The vendor should use the toll-free help line as a means of offering applicants and enrollees the opportunity to apply for or renew coverage over the telephone. The help line must be available during customary business hours (Monday through Friday) and provisions for leaving messages must be available during non-operational hours. Bilingual, multilingual, TDD, and TTY services must be provided. Calls must be logged to track and report telephone service performance areas (such as call volume, response time, live answer rate, length of time in queue, length of time on hold, and abandonment rate.

At a minimum, the vendor is required to staff internal help lines with individuals trained in:

• Cultural competency;
• Addressing the needs of special populations;
• The availability of and the functions of the Special Needs Unit provided by the Vendor; and
• The services which the vendor is required to make available to Delaware's CHIP Look Alike program enrollees.

C. Vendor Website

The vendor is required to have a Website containing CHIP Look Alike program specific information in English and Spanish. The Website must contain a toll-free contact number for both English- and Spanish-speaking consumers with questions. At a minimum, the following items must be included on the Website:

• How to Apply;
• Benefit Information;
• Participating Providers, including dentists;
• Frequently Asked Questions; and
• Costs related to enrollment in the program and utilizations of services.

D. Written Materials

The vendor is responsible for the issuance of written materials to applicants and enrollees. Written materials include but are not limited to: application forms; brochures; enrollee handbooks and subscriber agreements; and educational and preventive care programs that include an emphasis on health promotion, wellness, and healthy lifestyles and practices. The DHSS will provide direction for the content of certain types of notices and letters. All printed material should be understandable at the sixth (6th) grade level and available in English and Spanish. If Spanish is the preferred language listed for the family, all correspondence to the family must be in Spanish.

(a) **Application and Renewal Forms**

(b) **Brochures**

(c) **Enrollee Handbooks**

The vendor must provide to each new enrollee an Enrollee Handbook that provides all the information necessary to explain benefit coverage and services. Enrollee handbooks must be reviewed and approved by the DHSS prior to printing and distribution. Any subsequent updates to the Enrollee Handbook must also be submitted to the DHSS for review and comment prior to printing and distribution. The vendor must update its Enrollee Handbook at least annually, if applicable revisions have occurred.

(d) **Notices of Eligibility Determinations**

The vendor is required to provide notice regarding eligibility determinations.

(e) **Parental Education**

The vendor is required to provide information to parents or guardians to reinforce the importance of obtaining routine preventative health care services for their children that include an emphasis on health promotion, wellness, and healthy lifestyles and practices. The vendor is required to use data collected for QM/UMP purposes to determine the need for special, targeted informational activities about disease prevention, treatment, and management.

E. Eligibility, Enrollment, and Renewal Procedures

The vendor is required to determine initial eligibility, and to redetermine eligibility for enrollees on an annual basis. The vendor must provide sufficient personnel, staff time, and technology in order to meet the demands of eligibility and enrollment procedures in a timely manner as prescribed by the DHSS.

The vendor must have protocols in place to identify persons who may be eligible for Medicaid/CHIP under categories of eligibility for which Federal and state funds are available (e.g., pregnant women, persons with temporary or permanent disabilities, patients that may require transplants, etc.) and to refer them to DHSS. Protocols must include actions at time of application and renewal as well as periodic reviews of utilization data throughout the enrollment cycle.

In no instance may an eligible child be denied enrollment or coverage on the basis of a pre-existing condition.

The vendor is required to conduct supervisory reviews of negative actions that occur at renewal. This review is to include income changes that would move a family from the free or low-cost component to a higher premium program. Each Vendor is required to describe its process for supervisory review of negative actions that occur at the point of renewal.

F. Collection of Premiums and Co-Payments

The vendor is required to collect a monthly premium from the parent or guardian of the child(ren) eligible for the CHIP Look-Alike program. The vendor has sole responsibility for collection of these payments. The vendor must notify each enrollee's parent or guardian of any change in the monthly payment amount at least thirty (30) days in advance of any change.

The vendor shall notify the parent or guardian of the applicant that the child is eligible and invoice the parent or guardian of the applicant for his or her monthly premium. The notification shall, at a minimum, state the date the premium must be paid, the amount to be paid, and the address to which payment should be sent. The initial notification announcing enrollment after original eligibility determination and subsequent renewal determinations must include notification of the requirement for cost sharing, where appropriate.

G. Selection of Primary Care Provider (PCP)

(a) Assignment of PCP

Applicants must be required to select a Primary Care Provider (PCP). Vendors are encouraged to utilize multiple options for selection of a PCP- by phone, by mail, or online.

If the applicant has not selected a PCP at the time of application, the vendor shall require the enrollee to select a PCP within ten (10) calendar days of the date that eligibility has been determined. No enrollee may be denied coverage or terminated if he or she fails to select a PCP. If no selection is made within the specified timeframe, the vendor shall assign a PCP and the family will be so notified. The enrollee can elect to change his or her PCP selection for good cause.

The vendor may establish and maintain a referral process to effectively manage the care of its enrollees, but that process may not restrict access to medically necessary services. Enrollees shall be permitted to use providers of their choice to the extent that those providers are (except in emergencies) in the vendor's provider network.

(b) Primary Care Dentist or Other Provider

The opportunity for selection of a primary care dentist or other primary care provider may also be offered. The same selection rules as used for a PCP are applicable. The provider directory must include available dentists in the network.

H. Identification Cards

The vendor is required to provide an insurance identification card to each eligible child. The card must not specifically identify the holder as being in the CHIP Look-Alike program. Identification cards must be reviewed and approved by the DHSS prior to production and distribution.

I. Termination of Coverage

The vendor is required to terminate CHIP Look Alike program coverage if a child no longer meets the eligibility requirements. Termination will occur at the end of a calendar month.

J. Eligibility Review Process

An impartial Eligibility Review Process is available to applicants or enrollees or their parents or guardians who question a vendor's decision regarding eligibility for the program. The vendor must provide applicants and enrollees or their parents or guardians with a written notice of the opportunity for review of an adverse decision regarding eligibility for coverage. Information about this must be included in the letters of notification regarding eligibility decisions, enrollee handbooks, and application documents.

14. Other Requirements:

A. The vendor is required to have written policies and procedures for the quality and accessibility of care being provided in its network and to monitor utilization by its providers and enrollees.

B. The vendor may be required to file QM/UMP policies and procedures.

C. The vendor is required to comply with the requirements relating to compliance with national accrediting standards. Vendors should attach a copy of their latest NCQA certificate reflecting their accreditation status, if applicable. The vendor will be required to submit copies of future external reviews as they occur.

D. The vendor must have systems in place that provide for continuity of care and for case management of services.

E. The vendor must maintain and make available to the DHSS, upon request, studies, reports, protocols, standards, worksheets, minutes, or other such documentation as may be appropriate, concerning its QM/UMP activities and corrective actions.

F. The vendor must have written policies and procedures for maintaining the confidentiality of data and for complying with applicable state and federal laws and regulations.

G. External Independent Assessment

(a) The vendor must agree to cooperate fully with any authorized external evaluations and assessments of its performance under the terms of the contract. Independent assessments will include, but are not limited to, HEDIS/CAHPS reviews by an external review organization and any other evaluations required by state or federal statute or regulation by the DHSS.

(b) The vendor must agree to assist in the identification and collection of any data or clinical records and to cooperate fully with all external medical audit reviews that assess the vendor's quality of care. The vendor must make data, clinical records, and workspace available to the independent review team and the DHSS upon request and at a site selected by the DHSS.

(c) The vendor must submit a corrective action plan, as determined by the DHSS, and within timeframes established by the DHSS, to resolve any performance or quality of care deficiencies identified by the independent assessor as a result of the independent evaluation and/or by the DHSS.

H. The vendor is required have a certificate of authority from the Delaware Insurance Commissioner's Office to issue health insurance policies in the State of Delaware or to acquire such certificate prior to the effective date of a contract to provide health coverage under H.B. 139.

I. Risk Protection for High Cost Cases

In order to minimize risks that valid claims submitted to the vendor by providers for costs incurred by a CHIP Look-Alike program enrollee above a certain monetary threshold might not be paid. The vendor must have a risk protection arrangement in place until the contract expires. This risk protection arrangement must include reinsurance that covers, at a minimum, eighty percent (80%) of inpatient costs incurred by one (1) enrollee during one (1) year in excess of $150,000.

J. Equity Requirements

In addition to the vendor's responsibility to meet requirements of the DHSS, the vendor is required to meet financial standards for its contract and maintain those standards throughout the life of the contract. The purposes of the standards are to assure payment of the vendor's obligations to providers and to assure performance by the vendor of its obligations under the contract.

- $1.5 million AND

• The dollar amount of total adjusted net worth or total adjusted capital and surplus that creates an RBC ratio equal to 3.0 or above. Any RBC ratio below 3.0 will require negotiation with the DHSS for risk mitigation strategies and capital adequacy requirements.

If the financial position of a vendor is trending in a negative direction that threatens the solvency of the company and its ability to meet its obligations under the contract, the DHSS may take appropriate actions that include but are not limited to the following:

Discuss fiscal plans with vendor management;
Require the vendor to submit and implement a corrective action plan;
Submit an RBC plan;
Terminate the contract.

K. Medical Cost Accruals

As part of its accounting and budgeting function, the vendor must establish an actuarially sound process for estimating and tracking IBNRs. All program-related reserves must be maintained on the financial statements of the vendor. The vndor should reserve funds by major categories of service (e.g., hospital inpatient; hospital outpatient) to cover both IBNRs and RBUCs. As part of its reserving methodology, the vendor should conduct annual reviews to assess its reserving methodology and make adjustments as necessary.

L. Claims Processing and MIS

The vendor must have a claims processing system and MIS sufficient to support the provider payment and data reporting requirements specified in this RFP. Each Vendor should be prepared to document its ability to expand claims processing or MIS capacity should either or both be exceeded through the enrollment of program enrollees.

M. Financial Performance

The DHSS has the right to monitor the financial performance of the vendor and its major subvendors.

STATE RESPONSIBILITIES

Pursuant to the administration of the contract, the State agency would be responsible for such things as:

1. General responsibilities. The State Agency shall assume the following responsibilities with regard to this contract:

a. Notify the vendor in a timely manner of all pertinent changes in DHSS policy, procedures or operational systems that affect or depend upon vendor operations or activities.

b. Provide to the vendor, in a timely manner, any information regarding State or federal regulations, policies, or statues, or changes thereof, that are relevant to the vendor's performance.

2. Review and approve or indicate necessary changes in all informational and enrollment materials within fifteen (15) business days of receipt of said material.

3. General oversight of the vendor and the program. This could include receiving and reviewing reports from the vendor.

4. Provide to the vendor any other information that the State deems relevant in order for the vendor to fulfill the required duties.

5. Contract administration. Designate a project manager to represent the State on all matters pertaining to the contract.